

Ophthalmic Literature

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AN EXAMINATION IN OPHTHALMOLOGY.

For two years a definite movement has been in progress, seeking to bring about a higher standard of educational attainment for those who undertake ophthalmic practice as a specialty. Special committees of the American Ophthalmological Society, the Section on Ophthalmology of the American Medical Association and the American Academy of Ophthalmology have discussed and reported to their respective associations on methods for the accomplishment of this purpose. These reports have received the approval of each of these associations, and last year each committee was continued and authorized to cooperate with the others in preparing plans for joint action in carrying out the ideas already approved.

These committees have met and discussed this subject, and have now drawn up a plan endorsed by all the members of these committees. This plan was reported to the San Francisco meeting of the Section on Ophthalmology of the American Medical Association, and was unanimously accepted and endorsed by that body. It will also come before the American Ophthalmological Society before this issue of Ophthalmic Literature reaches its readers.

The leading features of this plan are the establishment of a board to arrange, control and supervise examinations, to test the preparation of those who design to enter upon the special or exclusive practice of ophthalmology. This board is also to fix the requirements to be met by all candidates for examination. These requirements shall include graduation from a medical college of recognized good standing, at least two years before the examination; and such subsequent study of ophthalmology as may be required by the board. The board is also authorized to prepare lists of medical schools, hospitals and private instructors recognized as competent to give the required instruction in ophthalmology. Each candidate reported as having successfully passed the required examinations is to receive a certificate or diploma setting forth that fact, but not conferring any academic degree. The board may appoint examiners from its own membership, or from the medical profession outside of its membership. The examinations may be held in any city of the United States where good facilities can be obtained for conducting clinical and practical examinations. The expenses are to be met by examination fees, but the board is to serve without compensation.

The advantages to be hoped for from such an examination are various. In the first place, the making of a clear distinction between those who have and those who have not made a proper preparation to practice ophthalmology is just as much needed as a clear distinction between those who have and those who have not prepared themselves

to practice medicine. No one now claims that preparation to practice medicine implies a sufficient knowledge of modern ophthalmology to undertake the work which properly devolves on any oculist.

Information as to who may fairly be expected to give the best advice in a case of eye defect or disease is needed by the community. But it is almost as much needed by the medical profession. Physicians too often have no means, except personal observation and judgment, of finding out whether a member of the profession who claims to be prepared for special practice really has the needed educational qualifications. Even the oculist referring a patient, who is traveling or removing to some distant part of the country, is often at a loss to know to whom in that region he can send the patient, with a reasonable prospect of moderately good treatment. Patients often have had to travel hundreds of miles to some one known to their original adviser, because he did not know of one who could give skilled assistance, and who was close at hand. The standard of attainment that will be required by a single board known to all the ophthalmologists of America, will have a far more definite value than can the "M.D." or even membership in a local medical society, granted as these are by scores or hundreds of different colleges or medical associations, with such enormously different standards.

But the examination proposed will be of equal value in the influence it will exert in the direction of improving the standards and methods of institutions and individuals engaged in training men for ophthalmic practice, and in the support that it will give to those who seek to raise these standards and improve these methods. In the past ophthalmic training in America has been sadly deficient in certain directions, notably in courses on the special anatomy and histology of the eye and on special pathology. Too many students of ophthalmology showed no interest in these branches—wanted rather to learn how to "refract" or get "a chance to operate." So it came about that the demands for "practical courses" being most common and insistent, were the ones commonly met. If a teacher started a course on physiologic optics, histology or pathology of the eye, so few were ready to take it that he became discouraged, gave it irregularly or discontinued it altogether. So it came about that when students who were ready to profit by such instruction came to seek it, they found it could not be obtained, or only at the cost of inconvenience and much unemployed time. Ophthalmic training in America has suffered greatly from this. But one of the first things the proposed board will have to do will be to lay down as preliminary requirements for such examinations, the courses that each candidate must show evidence of having taken, and from the list such branches as special anatomy, bacteriology and physiologic optics cannot be omitted. A demand for instruction in these branches will at once be created and will in turn develop the needed opportunities of such instruction.

Again such examinations will produce a healthy competition among institutions and teachers engaged in supplying ophthalmic instruction. Heretofore almost the only competition among them has been in the direction of securing students. Incidentally the offering

of apparent advantages, in the way of clinical opportunities, showy apparatus and imposing hospital buildings, has entered into this competition. But thoroughness of work, improved methods, insistence on accuracy and devotion of sufficient time to necessary details have been largely neglected. The direct supervision of educational methods that such a board will have to put into operation will be felt in every department of ophthalmic teaching. These are but a few of the possibilities for good that lie in this movement for an Examining Board, controlled and supported by the ophthalmologists of America through their already developed organizations. How that support may be given to the movement may well be a subject for careful consideration. We will have something to say of it in the future.

OUR NEXT NUMBER.

Following a custom common among the European special journals, *Ophthalmic Literature* will probably not appear at the beginning of August, but a July-August number, containing the index of ophthalmology for both months, will be published later. There are various reasons for adopting this plan, some of which bear most heavily on the editor and his assistants, but others may also be felt by the reader.

THE NEW YORK OPHTHALMOLOGICAL SOCIETY.

In January, 1864, the movement for the organization of the American Ophthalmological Society had been started by a meeting at which seven of the eight who were present were New York men. On March 7th of that year ten New York physicians interested in ophthalmology organized the New York Ophthalmological Society, which is believed to be the oldest local ophthalmological association in the world. The original members were: C. R. Agnew, H. Althof, J. F. Bumstead, W. H. Carmalt, J. H. Hinton, H. D. Noyes, D. B. St. John Roosa, H. B. Sands, F. Simrock and William Stimson. Of these, six had severed their connection with the society within five years. But by that time nine new members had joined the society, including E. G. Loring and Herman Knapp. Of the original members but one—Dr. W. H. Carmalt of New Haven—is still living. At the beginning of the present year the active members numbered forty-three, and there were four honorary members.

During the first few years of the society's existence it contained a number of members who practiced ophthalmology only as an incidental part of their general work, and who soon gave up eye work altogether. Such were Bumstead, Sands, Hackley, Wier, Watts, Delafield, J. H. Emerson, Edward Curtis and Woolsey Johnson. For a still longer period it included men who devoted themselves mainly or exclusively to otology; for example, Simrock, Buck, Sexton and Bacon. Indeed, at the outset it was specifically designed to include both specialties. Since about 1878, when some of the most prominent otologists resigned their membership, it has been devoted to ophthalmology exclusively.

From the beginning it is believed the meetings have been held after the following fashion: Each member in succession entertains

the society, either at his own house or elsewhere, as he sees fit. For a number of years the meetings, almost without exception, have been held at Sherry's restaurant. For a good many years at all events meetings have been held on the second Monday of every month, except during the summer.

The regular order of business is as follows: Members assemble at 8 o'clock; and, after hearing the minutes which usually record the proceedings of the previous meeting in considerable detail, have a scientific session. This consists of presentation of patients, presentation of instruments and specimens, and verbal reports of cases. No formal papers are ever read; although in presenting patients or reporting cases, the members often read carefully prepared case histories, accompanied by diagrams, charts and illustrations. Once or twice it has been suggested to have a stenographer to take down the proceedings for publication, or rather circulation among the members; but this proposition never met with great favor, and perhaps in consequence of this, the conduct of the meetings has always been quite informal. At 9:45 p. m. the society goes into executive session, and at 10 o'clock sits down to a supper provided by the host of the evening.

There is no fixed limit of membership; but for the last twenty years the usual number has been between thirty-five and forty.

ALEXANDER DUANE.

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Vogt, A. Studies of Erythropsia From Dazzling in the Aphakic Eye, and Light Extinction by Cataract; With Remarks as to the Disturbance of Color Sensation Occasioned by Dazzling. (*Archiv für Augenheilkunde*, v. 78, p. 93.)

The author's conclusions are based upon a series of observations of living subjects, including himself, and upon light measurements made with special apparatus upon normal and cataractous eyes. It was not possible to produce erythropsia either in normal or in aphakic eyes, by the use of pure concentrated ultraviolet light, even when this was of much greater intensity than is found in nature. On the other hand, the perception of erythropsia may be easily caused in anyone by dazzling with visible light containing green rays in large quantity; one eye being used as a control eye. Of the components of the visible spectrum only light of wave lengths of about 500 to 570 millimicra is capable of producing erythropsia. The author suggests the relative harmlessness of the ultraviolet light present in daylight and in other light sources commonly employed, and the inappropriateness of yellow glass globes. He finds the chief cause of the relative frequency of marked erythropsia in aphakic eyes in the relative dark adaptation of the retina which existed before extraction of the lens. His experi-

ments and measurements show this dark adaptation to be due to the clouding of the lens, and in advanced years also to its amber discoloration. Since through multiple reflection, dispersion, and absorption the light reaching the retina of the cataractous eye receives a reddish tinge, the retina develops a hypersensitiveness especially for green light. An important condition for the perception of erythropsia, as of every entoptic phenomenon, is the control eye. In the absence of a control eye, the aphakic subject is just as likely to overlook erythropsia as the normal person.

Calderaro. Researches on the Opsonic Power of the Aqueous Humor in Diabetes. (*La Clinica Oculistica*, 15th year, pp. 1 and 88.)

The researches were conducted in part on man, utilizing the aqueous humor of three cases of diabetes with bilateral cataract; but in the main on animals made diabetic with injections of fluorescein or adrenalin (rabbits and dogs), or by extirpation of the pancreas (cats and dogs).

In man the first aqueous humor of either healthy or diabetic individuals did not show an opsonic power exceeding that of physiologic solution of sodium chloride. The second aqueous, collected as soon as the chamber was reformed (averaging three hours), in health showed opsonic power from six to thirteen times greater than that of the first aqueous, and equal to about half the opsonic power of the blood serum of the same individual; whereas in the diabetic individual the opsonic power of the second aqueous was merely two or three times greater than that of the first aqueous, and was less than one-third of the opsonic power of the blood serum of the same patient. The temporary disappearance of glycosuria under appropriate diet did not raise the opsonic index of the blood serum, nor the opsonic power of the second aqueous.

In animals experimental diabetes was always accompanied by reduction of the opsonic power of the blood serum, and consequently also of the second aqueous humor during the first four hours after paracentesis, but whereas this fact was observed early in the diabetes produced by adrenalin or extirpation of the pancreas, in diabetes from fluorescein the change was observed only late, when the animal was in very bad condition. The opsonic power of the first aqueous of animals rendered diabetic did not differ at all from that of the first aqueous of normal animals.

In experimental diabetes, with diminished opsonic power of the blood serum and of the new-formed aqueous, subconjunctival injection of 10 per cent. chloride of sodium solution, or pyogenic infection of the cornea, caused a slow and scanty passage of opsonins into the first aqueous, compared with what is seen in normal animals. The reduction of opsonic power of the aqueous in these cases did not depend on the abnormal glucose content of the aqueous, but merely on the diminished opsonic power of the blood serum.

The increased gravity of pyogenic infections of the cornea in animals made diabetic depends chiefly upon the limited passage of opsonins into the aqueous and into the lymph spaces of the cornea. The diminished opsonic power of the blood serum and of the aqueous in experimental diabetes can be raised by injections of Wright's serum.

The changes in the ciliary epithelium produced by the injection of fluoride of sodium into the anterior chamber facilitate the passage into the aqueous of glucose and of the opsonins circulating in the blood.

Guglianetti, L. Cicatricial Processes Secondary to Antiglaucomatous Corneosclerectomy; Permeability of the Cicatrix. (*Archivio di Ottalmologia*, 22nd year, pp. 150 and 169.)

In three human eyeballs affected by secondary glaucoma, operated upon by Elliot's method, the trephine hole was found completely obstructed by compact fibrous cicatricial tissue whose morphologic as-

pect much resembled that of the sclero-corneal tissue which had been removed. In 50 experimental operations on rabbits' eyes, especially by the methods of Holth and Elliot, a lasting typical fistula was in no instance obtained. In one case only was a subconjunctival protrusion noted, but here there was a prolapse of the base of the iris, which completely covered the protrusion and prevented infiltration of the aqueous into the conjunctiva. In every other instance the sclerocorneal tissue removed was replaced by fibrous cicatricial tissue derived from proliferation of the connective tissue of the cornea, conjunctiva, and sclera. In the great majority of the rabbit eyes operated upon microscopic examination showed more or less extensive incarceration of the iris, which often escaped simple clinical observation.

After injection of uranin into the rabbit's abdomen, this substance was distributed to the eye which had been operated upon in a manner not clearly differing from what occurred in the other eye. Uranin injected into the anterior chamber was never found to pass into the conjunctiva through the cicatrix, even in cases in which this was as recent as one week. The scar tissue was found to be impermeable to granules of India ink injected into the anterior chamber. But when iris tissue was incarcerated in the scar, India ink passed through the cicatricial tissue by way of the folds of iris; and if the incarceration was large and prominent, the ink reached the conjunctiva within the first few hours after injection.

Guglianetti remarks that these researches support the hypothesis according to which so-called scleral or corneo-scleral fistulization is determined by the presence in the wound of uveal tissue or other substance extraneous to the tissues incised.

Pissarello, C. Spontaneous Hemorrhage Into the Orbit. (*Archivio di Ottalmologia*, 22nd year. p. 129.)

A man of 47 years, while working in the fields, had a severe headache which lasted two hours. The next morning his left eye was much more prominent than the right. The exophthalmos increased for three days, at the end of which time the patient came to the clinic. The left eye appeared to be almost completely luxated outside the orbit, and was also 1.5 cm. lower than the right, although both orbits were symmetrically placed. The eye was immobile. There was marked general arterio-sclerosis, with blood pressure of 160-165 mm. Hg. The case was diagnosed as one of spontaneous subperiosteal hematoma of the vault of the orbit, and aspiration with a syringe brought away about 8 ccm. of a bloody fluid. The exophthalmus diminished, but after a short time returned to its former condition; and as the cornea was ulcerated, the patient was anesthetized and an incision made below the supraciliary arch. A large amount of blood was evacuated from a space between the bone and periosteum of the roof of the orbit. The eye was kept closed for three weeks by suture of the lids, and the patient made an excellent recovery, with vision of 20/40.

Deutschmann, R. Sclerectomy and Trephining by Elliot's Method, with Remarks on the Genesis of Choked Disk. (*Beiträge zur Augenheilkunde*, 89th part, p. 659.)

Two groups of cases are reviewed statistically. All were operated upon between January, 1911, and November, 1914. In the early part of the period sclerectomy was largely used, the last operation of this character being done in February, 1912. From that date Elliot's trephining was exclusively used. Of 41 sclerectomies done without excision of the iris, only four showed permanent reduction of tension to 25 mm. or less; two of these cases having previously undergone unsuccessful iridectomy. In five cases the patient was lost sight of. In the rest of the remaining thirty cases the tension was at least 30 mm. Of six cases in which sclerectomy was combined with iridectomy

four, all cases of acute glaucoma, gave good results. A like effect was had in one case of glaucoma simplex, but the remaining case did badly, coming to enucleation. Of the thirty cases of sclerectomy in which the tension after operation was not less than thirty mm., 12 retained a tension between 30 and 35 mm., but without marked disturbance and (sometimes under regular use of pilocarpin) without appreciable lowering of visual acuity. In the other 18 cases there was marked rise of tension after a few weeks or even after a few days, rendering further operative procedures necessary. Thus of 48 sclerectomized glaucomatous eyes, 11 gave satisfactory and 31 unsatisfactory results; and five patients were lost sight of.

In the trephined cases Elliot's technique was closely followed. Deutschmann regards the integrity of the conjunctiva over the trephine opening as important, and in the event of a tear occurring always sutures with fine silk in such fashion that the break does not lie directly over the trephine hole. His only case of late infection was in an eye trephined at the inferior limbus. Of 163 trephinings of glaucomatous eyes 90 gave permanently good results, and 52 were without lasting results. The later course of the remaining cases could not be followed. Of a total number of 178 trephine operations, some of which were done for rise of tension, incarceration of the iris in the trephine hole was later observed in 8 cases; and vitreous prolapse in 7. In 5 cases the trephined disc could not be recovered, but was left in the eye. The last named accident did not seem to produce harmful results.

Of the 90 cases in which increase of tension was permanently corrected, 49 showed a leaky bleb; 21 showed an open trephine site without macroscopic seepage; and in 20 nothing was to be seen of the trephine site. Of the 52 unsuccessful cases, there was a leaky bleb in 2; 17 showed an open trephine site without macroscopic seepage; and in 33 nothing was to be seen of the trephine site. Of 151 trephined eyes in which the results as regards visual acuity were observed for a sufficient length of time, one lost the remains of visual acuity; eleven recovered the previously much lowered visual acuity; 79 retained the visual acuity and field unaltered during the period of observation; 22 got slowly worse without complete loss of vision; in 11 the vision was completely lost; and 9 were operated upon solely to lower the tension and without hope of vision.

Behr has maintained that traumatic lowering of tension is followed by edema of the optic disc. Deutschmann therefore trephined four cases of optic atrophy and two of retinitis pigmentosa; and sclerectomized six eyes with optic atrophy, to discover whether the improved nutrition of the nerve which according to Behr's statement might be supposed to exist would produce an improvement in the pre-existing condition. In none of these cases was it possible to discover any papilledema, or even a transitory fullness of the fundus vessels. Moreover, in each of these cases, with one exception, the tension rapidly returned to normal after the first 5 to 8 days; and later examination showed scarcely a trace of the operative site.

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